Group Census Employee Form

Employee Name: _____ DOB: _____ Gender (M/F): ____

Spouse Name: _____ DOB: _____ Gender (M/F): ____

Dependent 1: _____ DOB: _____ Gender (M/F): ____

Dependent 2: _____ DOB: _____ Gender (M/F): ____

Dependent 3: _____ DOB: _____ Gender (M/F): ____

Dependent 4: _____ DOB: _____ Gender (M/F): ____

Address: _____ Zip Code: _____

Job Title: _____

Full Time or Part Time: _____

Average Hours Worked per Week:_____

Estimated Yearly Salary:_____

Current Health Coverage (please circle): Employer or Other

If Employer, type of plan: _____

If Other, explain coverage: _____

Other coverage can be: Spousal Plan, Husky/Medicaid, Exchange/AccessHealthCT, Medicare, None